Testimony of Heidi M. Zabik
Senate Insurance Committee
June 5, 2012

Dear Honorable Chairman Hune and Members of the Senate Insurance Committee:

Thank you for allowing me to share what happened in 2009. I went in for a routine surgery procedure that ended up anything but routine.

Fifteen hours after my surgery, my pain had become unbearable. Finally a nurse came another hour later and gave me a morphine shot. But by that point the pain had gone unchecked so long that morphine was not working, so she gave me a different drug called dilaudid and then left the room. Within minutes, I stopped breathing. I wasn't hooked up to any monitoring so if not for my husband screaming for help when he saw me turn blue, I would be dead right now. They did CPR, broke my ribs, gave me something to reverse the effects of the dilaudid, and thank goodness I'm here today.

Could you imagine being that nurse? Returning to my room and I'm dead? There's no amount of resuscitation that could have saved me. I spent two extra nights in the hospital in the "monitored care" section and my cost of care rose to total $37,377.

There's a certain amount of terror that keeps a person up nights after an ordeal like that. Fear of being alone, fear of falling asleep, not just my fear, but my husbands as well. Having to tell what happened to loved ones, my son…my daughter…the look in my parents eyes…..And not knowing how and why this happened?

So began my quest for information.

I wanted to believe that this was a rare thing, so I began researching. Instead, I learned that adverse reactions are the most likely complication and the number one thing nurses should watch for after giving pain medications…especially when a patient has no prior history with the drug…which I didn't…and she'd asked me. If only she'd have stayed to monitor me as standard protocols recommend.

I researched some more. And was horrified to find out that 1 in 45 hospital patients experience some type of postoperative respiratory complication when admitted for a non-life threatening, non-cardiac condition…but only the ones who DIE get reported!!! Furthermore, these types of complications are over 5 times more likely to be the result of a medical error than other types of classifications.

I began calling the hospital, looking for answers. At first, no phone calls were returned. Then I got the explanation of benefits from my insurance company, and realized that not only did they almost kill me, but the hospital billed and profited from the harm they had caused me! What a cruel business model! Where is the disincentive to minimize or eliminate medical errors? In my case, I was looking for assurance that what happened to me couldn't happen to someone else tomorrow and the next day.

So I called my insurance company, and begged them not to pay the hospital bill. I thought that if the hospital was required to absorb the cost of their medical error, then they'd be more likely to adopt best practices to increase patient safety standards. But it turns out that there is NO MECHANISM whatsoever that allows the insurance company to NOT pay the bill, or to only pay for the care that was properly performed.

I finally gained access to a person at the hospital from their Patient Relations Department, who empathized with my story, and then asked me what resolution I was hoping to achieve. I explained that I was not looking for monetary compensation. I only wanted some real assurances that what happened to me would not go unaddressed and that other patients would be safer in their hospital from them having learned from the mistakes made with my care. While the hospital never did formally admit responsibility, they did arrange for

me to openly discuss my concerns with the supervising nurse of the hospital wing responsible for my poor care. Again, there was no formal admission of wrongdoing, but I received some degree of closure at knowing that they would be using my medical file for a training exercise with the staff.

It was only my ability to research and knowing how to push back against a large and daunting system that I got even the small degree of closure that I did get. I knew full well how to advocate for myself and for better patient safety, and I would hardly call a promise to have my case file reviewed by the staff of one wing of one hospital a victory for increased patient safety. Yet that seemed to be the best I could get. And that has always worried me.

I am still baffled as to why a hospital would choose to engage in such a cruel business model? They didn't have to admit any wrongdoing, and they even got to bill and profit from their error. It only makes sense that, to learn from their mistakes, a better model would be for hospitals to adopt policies that allow for immediate and open communications between staff and patients, the full disclosure of errors, the ability to admit mistakes without fear of reprisal, and the training and support to adopt best practices for future patient care.

As I continue to stay educated on this issue I've discovered that some of the things I had asked for during my ordeal were concerns that other hospitals have begun questioning as well. So just imagine how vindicated I felt to discover that just such a model actually exists across an entire hospital system--and it's at the University of Michigan! Some hospitals are starting to realize that a system which allows medical errors to go unreported or, even worse, hidden cannot improve patient safety.

We cannot afford NOT to address this epidemic in patient safety and medical errors. The best way to ensure that Michigan retains its top notch medical providers and facilities is to create a medical environment where patient safety is the best practice, and hospitals have incentives to reduce and eliminate medical errors. I urge you to vote no on these bills in their current form, and look instead at how we can encourage a business model, such as the one used at U of M, to actually help people and improve patient safety.

Thank you for your time.